

Michael D. Borookhim, M.D.  
9301 Wilshire Blvd. Suite 602  
Beverly Hills, CA 90210  
Ph.: (310) 288-0881  
Fax: (310) 288-0896

PATIENT INFORMATION												
<b>Patient Name</b>									<b>Address:</b>			
	<b>Last Name</b>				<b>First Name</b>				<b>Apt./Unit/Suite No.:</b>			
<b>SSN</b>						<b>Other ID (DL,etc)</b>						
	<b>City</b>		<b>State</b>			<b>Zip code</b>						
<b>Date of Birth</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>Sex:</b>	<input type="checkbox"/>	<input type="checkbox"/>			<b>Home Phone:</b>		<b>Cell :</b>	
	<b>M</b>	<b>D</b>	<b>Y</b>		<input type="checkbox"/>	<input type="checkbox"/>			<b>Work:</b>		<b>Pager:</b>	
<b>Marital Status</b>	<b>Single</b>	<b>Married</b>	<b>Widowed</b>	<b>Other</b>						<b>Email address:</b>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<b>Referred by:</b>		
<b>Employment Status</b>	<input type="checkbox"/>	<b>Full Time</b>	<input type="checkbox"/>	<b>Student</b>						<b>Address:</b>		
	<input type="checkbox"/>	<b>Part Time</b>	<input type="checkbox"/>	<b>Unemployed</b>						<b>Phone:</b>		
	<input type="checkbox"/>	<b>Self-Employed</b>	<input type="checkbox"/>	<b>Retired</b>						<b>Fax:</b>		
<b>Employer :</b>												
<b>Address:</b>												
GUARANTOR INFORMATION												
<b>Name of person who is financially responsible for the Patient (if different from the above) :</b>												
<b>Address:</b>									<b>Home Phone:</b>			
									<b>Relationship:</b>			
INSURANCE INFORMATION												
<b>Insurance 1</b>						<b>Insurance 2</b>						
<b>Company:</b>												
<b>Address:</b>												
<b>Phone:</b>												
<b>Plan Type</b>												
<b>Policy No.</b>												
<b>Group No</b>												
EMERGENCY CONTACT												
<b>Name :</b>								<b>Relation:</b>				
<b>Address:</b>												
<b>Home Phone :</b>						<b>Work Phone:</b>						
<b>Cell Phone:</b>						<b>Other:</b>						
Does the patient has Advance Directives? (Advance Directive is a written personal statement of how medical care choices should be made and who should make them in the event you are unable to communicate, such as from having a severe injury or illness. Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>												

**FINANCIAL AGREEMENT :** The undersigned agrees, whether s/he signs as an agent or a patient, that in consideration of the services to be rendered to the patient s/he hereby individually obligates himself to pay the full costs thereof, in accord with applicable laws. Such payment shall include medical services and/or professional services in the prevailing amount set by the management. The undersigned hereby assigns to Michael D. Borookhim, M.D., Inc. and authorizes payment directly to them, all insurance benefits for medical services and/or professional services otherwise payable to or on behalf of the patient, but not to exceed the regular rates and fees for services rendered to the patient.

\_\_\_\_\_  
Patient or Responsible Person Signature

Date |  |  |   
M | D | Year

